MAR 3 1992

No. 91-1283

IN THE

Supreme Court of the United States

OCTOBER TERM, 1991

FRANK GREENBERG, Independent Executor of the Estate of John W. "Jack" McGann,

Petitioner,

— v.—

H & H MUSIC COMPANY, BROOK MAYS MUSIC COMPANY, AND GENERAL AMERICAN LIFE INSURANCE COMPANY,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

MOTION AND BRIEF OF AMERICAN PUBLIC HEALTH ASSOCIATION, AIDS ACTION COUNCIL, JESSICA DAVIS, M.D., GAY MEN'S HEALTH CRISIS, MICHIGAN ORGANIZATION FOR HUMAN RIGHTS, NATIONAL LEAGUE FOR NURSING, NATIONAL ASSOCIATION OF PEOPLE WITH AIDS (ATLANTA CHAPTER), AND THE UNIVERSITY OF MICHIGAN PUBLIC HEALTH LAW CLINIC AS *AMICI CURIAE* IN SUPPORT OF PETITIONER.

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March 3, 1992

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Respondents.

MOTION FOR LEAVE TO FILE BRIEF AS AMICI CURIAE

The American Public Health Association ("APHA"), AIDS Action Council, Jessica Davis, M.D., Gay Men's Health Crisis ("GMHC"), Michigan Organization for Human Rights ("MOHR"), National League for Nursing ("NLN"), National Association of People with AIDS ("NAPWA") (Atlanta chapter) and the University of Michigan Public Health Law Clinic, by their attorney, move this Court to grant them leave to file a brief in support of the Petition for Grant of Writ of Certiorari, and in support of this motion, show as follows:

1. The Defendants, H & H Music Company, Brook Mays Music Company, and General American Life Insurance Company,

have refused consent to the submission of this *amici curiae* brief.

2. Applicants' interest in the issues in, and the outcome of, this petition stems from their recognition that insurance caps in AIDS-related cases will harm the nation's already fragile health care system and will unfairly restrict AIDS patients' critical access to medically necessary treatments.

2. Applicants believe that a brief *amici curiae*, submitted by applicants, would be desirable in that the issues involved in this case concern not only the parties and applicants, but are also of considerable public interest and import, and it is therefore highly important that Petitioner's position be developed and presented fully.

Respectfully submitted,

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STATEMENT OF INTEREST OF AMICI CURIAE

Amici American Public Health Association, AIDS Action Countil, Jessica Davis, M.D., Gay Men's Health Crisis, Michigan Organization for Human Rights, National League for Nursing, National Association of People with AIDS (Atlanta Chapter), and the University of Michigan Public Health Law Clinic share a common professional opinion--that insurance benefit caps such as the one at issue in this case are contrary to the law, damaging to the nation's health care system, seriously detrimental to the people with HIV infection who are subject to them, inherently discriminatory, and based on misconceptions regarding the relative cost of caring for people with HIV disease.

Amici, who include some of the nation's leading experts in the area of

public health and social policy, as well as several of the leading providers of services to people with HIV infection, all have a strong interest in the outcome of this case and believe their views can be of special interest to the Court.

American Public Health Association ("APHA") is a national organization devoted to the promotion and protection of personal and environmental health and to disease protection. Founded in 1872, APHA is the largest public health organization in the world, with over 50,000 members. It represents all disciplines and specialities in public health, including patients and health professionals such as physicians, nurses, health educators, and family planning specialists. APHA also publishes a technical

report series dealing with various aspects of the HIV epidemic through the American Journal of Public Health, as well as numerous books related to HIV and state-of-the-art research.

AIDS Action Council, founded in 1983, is the only national organization devoted solely to the public policy issues presented by the AIDS crisis. The AIDS Action Council has established a coalition of national organizations representing the various constituencies affected by AIDS which meets monthly to review federal legislation and support appropriations that comprehensively address all AIDS-related issues.

Jessica Davis, M.D., is an associate professor of clinical pediatrics and genetics at Cornell

University Medical Center. She specializes in clinical genetics and chronic illnesses. Dr. Davis is a president of the Council of Regional Networks, a member of the Alliance of Medical Genetic Support Groups, College of Medical Genetics, and on the Medical Advisory Board of the National Mars An Association and Tay Sachs Association. Dr. Davis has treated a number of children with AIDS.

Gay Men's Health Crisis ("GMHC"), a New York not-for-profit corporation, is the nation's oldest and largest AIDS service and education organization. GMHC currently provides a range of support services to more than 4,500 clients with AIDS and HIV illness each year. Many of GMHC's clients remain able to

work despite their illness, and are dependent upon the health insurance they receive through their employment to afford medical care. These clients are among the individuals who would be damaged by policies, such as the respondents' in this case, that impose arbitrary caps upon the dollar amount of AIDS-related coverage that is provided. Through its Legal Services and Financial Advocacy programs, GMHC counsels and represents individuals who do not receive the health care or health insurance benefits to which they are entitled. Accordingly, GMHC has both an institutional interest and an interest on behalf of its clients in the outcome of this litigation.

Michigan Organization for Human Rights ("MOHR") is a statewide gay

and lesbian rights organization in Michigan. MOHR has a mailing list of over 13,000 people and has been involved in AIDS legal issues for the past eight years. MOHR has an AIDS advocacy program which has, over the past two years, focused on AIDS-related public policy issues.

National League for Nursing ("NLN"), which originated in 1893 as the American Society of Superintendents of Training Schools for Nurses, is a non-profit coalition of nurses, other health care professionals, and consumers working to improve the quality of health care. NLN pursues its quality mission as the national accrediting body for nursing education programs, and through consulation services, continuing education programs, test

services, research, publications, and lobbying efforts on behalf of nursing and consumers. NLN's subsidiary, the Community Health Accreditation Program, was recently recommended by the Health Care Financing Administration for "deemed status" as the nation's only independent accrediting body dedicated solely to elevating the quality of care in the home care and community health arenas.

National Association of People with AIDS ("NAPWA") (Atlanta Chapter) is the only membership coalition in the State of Georgia made up of people living with HIV infection. The mission of the volunteer-based organization, which has over 1,800 members, is to enhance the quality of life of HIV-affected individuals

through education, advocacy and community leadership. NAPWA's program focuses on providing treatment information and peer counseling, publication of a monthly newsletter and advocacy on behalf of people infected with HIV.

The University of Michigan Public Health Law Clinic is a clinical law program which, in the past three years, has had approximately 50 law students participate on AIDS legal issues. Under the direction of Professors David Chambers and David Piontkowsky, the students have drafted briefs, filed cases, and argued before federal and state courts on behalf of indigent clients with HIV. The Clinic has had AIDS-related issues as its focus for the past three years.

Amici submit this brief so that this Court will have available for its deliberations an accurate statement of the position of public health experts and AIDS service providers regarding the important issues presented by this appeal.

STATEMENT OF THE CASE

Amici rely on the Statement of the Case set out in Brief for Appellants.

SUMMARY OF THE ARGUMENT

The health care needs spawned by the AIDS crisis have three primary sources of funding: private insurance, Medicaid, and hospitals which provide uncompensated care. Medicaid and uncompensated care form the nation's health care "safety net". They exist essentially to fill a gap created by the inability of the private insurance industry to provide coverage for everyone. In other words, they represent a "last resort" in the health care financing process. Thus, from a public health perspective, private insurance represents the optimal choice for funding HIV/AIDS-related health care.

Two major reasons inform this conclusion. First, Medicaid reimbursements are far below those provided through private insurance. Consequently, the medical establishment has a financial incentive to minimize its treatment of Medicaid recipients. Secondly, uncompensated care provided by hospitals should be reserved for the truly indigent and uninsured. Current data reveals that the nation's AIDS population already depends heavily on the "safety net"

The Fifth Circuit's decision artificially expands the ranks of the uninsured; previously insured employees like John McGann are now forced to turn to the "safety net". Both the Medicaid program and the ability of the nation's hospitals to continue providing uncompensated care will be sorely tested.

Given the financial incentives for many employers to adopt McGann-like health benefit caps, the threat to an already overburdened health care system is very serious. Already, public hospitals that disproportionately bear the burden of treating indigent and uninsured persons with AIDS are suffering significant financial losses.

Unfortunately, amidst all this analysis of costs, the lower courts have lost sight of the fact that without adequate coverage for health care costs, HIV-infected persons cannot take advantage of medical treatments necessary to meaningfully extend their lives. The prophylatic use of AZT (to delay the onset of an extremely deadly form of pneumonia) is one such promising treatment. Of course, when an opportunistic disease does strike a person with HIV, the need for

protection from catastrophic health care costs becomes even greater.

Therefore, amici urge the Court to find that the caps on benefits enacted by H & H Music Company is a discriminatory practice, cruelly denies employee health benefits at a time when they ar most needed, do not represent a valid form of cost containment and should not be sheltered by ERISA.

ARGUMENT

IF PERMITTED TO CONTINUE, THE DISCRIMINATORY PRACTICES APPROVED BY THE FIFTH CIRCUIT'S DECISION WILL SUVERT THE CONGRESSIONAL INTENT, FURTHER JEOPARDIZE THE NATION'S ALREADY OVERBURDENED HEALTH CARE SYSTEM, AND ULTIMATELY, IMPEDE THE SURVIVABILITY OF HIV-INFECTED PERSONS.

A. Denial of promised job-derived health insurance benefits will force many HIV-infected persons to rely on the inferior health care financing alternative of Medicaid as well as pressure hospitals to

undertake even greater levels of uncompensated care.

In 1991, the National Commission on Acquired Immune Deficiency Syndrome reported that individuals with AIDS faced three primary options for funding their care: private insurance (through either a job-based or an individual policy), Medicaid, and good fortune. National Commission on Acquired Immune Deficiency Syndrome, America Living With AIDS 70 (1991) [hereinafter National AIDS Commission Report]. The final category encompasses the generosity of others upon which the nation's uninsured depend for their health care needs. An important component in this third category is the "uncompensated care" that both public and private hospitals provide to indigent patients.

In passing ERISA, Congress reocgnized that, from a public health perspective,

private insurance represents the optimal choice for funding HIV/AIDS-related care. Despite its virtues as the federal health insurance program for the poor, Medicaid does not match the financial reimbursement capabilities of the private insurance industry.

> [W]hile Medicaid is preferable to having no insurance at all, it differs from private insurance in certain critical ways that affect Medicaid recipients' access to care. In many states, Medicaid pays <u>much lower rates</u> to physicians than does private insurance. Chiefly for this reason, most office-based private physicians avoid or limit their acceptance of Medicaid recipients (emphasis added).

Jesse Green & Peter S. Arno, <u>The 'Medicaidization' of AIDS</u>, 264 JAMA 1261 (1990).

Medicaid's payment scheme in two cities with the highest concentration of persons with AIDS is fairly indicative of this dismal truth. "[P]hysicians are reimbursed by Medicaid an average of 33% of the rates paid by private insurance in

San Francisco and 15% in New York." Id. at 1264. The reality in health care financing is that Medicaid is simply not an adequate replacement for private insurance.

Moreover, Medicaid is intended to serve only the very poor in this country, rather than the larger pool of people who are without private insurance. "Although Medicaid is designed to cover low-income people, it falls short of serving the needs of many poor individuals because of the stringent criteria defining 'low-income' and the prerequisite that assets be below a certain minimum." National AIDS Commission Report, supra, at 73. Sadly, the segment of the AIDS population that is not protected from catastrophic health costs by either private insurance or public insurance is sizable:

approximately 29% of the nation's AIDS population is uninsured. Id. at 70.

To a significant extent, these uninsured persons with AIDS depend on the ability of the nation's hospital system to provide them with charge-free care. With the number of uninsured Americans growing and Medicaid's inability to provide reimbursements at market price, hospitals have responded to this aspect of the nation's health-care crisis by devoting ever-increasing resources toward the provision of uncompensated care. The statistics are startling. "In 1980, uncompensated care cost $3.5 billion, representing 4.6 percent of total costs. By 1986, the annual cost of uncompensated care had risen to $8.4 billion or 6.0 percent of total costs." American Hospital Association, AIDS/HIV Infection: Recommendations for Health Care Practices

and Public Policy 46 (1988) [hereinafter AHA Report]. While it does not purport to address the health care needs of all the nation's uninsured, nonetheless, hospital-provided uncompensated care, like Medicaid, remains an indispensable and permanent part of the nation's health care financing process.

Clearly, Medicaid and uncompensated care fill a gap created by the inability of the private insurance industry to provide coverage for everyone. Unfortunately, the Fifth Circuit's decision below expands this gap unnecessarily. As the nation's health care "safety net", Medicaid and uncompensated care is reserved for those persons for whom the private insurance alternative is truly unavailable. By revoking promised health benefits for a specific disease like HIV infection, self-

insured employers such as H & H Music Company artificially inject their employees into the ranks of the uninsured.

Given the costs associated with a catastrophic illness such as HIV infection, reliance on personal resources will be extremely difficult for most employees.[1] Without the protection of insurance and after expending personal resources, employees in the position that John McGann was placed necessarily will turn to Medicaid and uncompensated care to provide for their vital health care needs. The only remaining "option" would be to forgo the medical treatments necessary to combat HIV infection. By sanctioning

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[1]The latest study projects that treatment for a person with AIDS costs $32,000 per year and $85,133 per lifetime. The same study also estimates that medical care for an HIV-infected person without AIDS amounts to $5,150 per year. Fred J.Hellinger, Forecasting the Medical Care Costs of the HIV Epidemic: 1991-1994 Forecasts, 28 Inquiry 213, 219, 222-3 (1991) [hereinafter Hellinger 1991-1994 Forecasts].

employers who abandon their promise to provide for employee health care costs, the Fifth Circuit ultimately has shifted responsibility for much of the costs normally paid by insurance unto the public sector and public-minded hospitals. Such a shift augurs poorly for the health of health care in America.

B. This deterioration in HIV-related health care financing seriously threatens the integrity of the nation's health care "safety net".

The response of the nation's health care "safety net" to the HIV epidemic has been noticeably burdensome. From a disbursement perspective, Federal involvement has been substantial. "Medicaid is currently the most important source of financing for AIDS and HIV-related health care benefits." National AIDS Commission Report, supra, at 72. Approximately 40% of this nation's AIDS

population depend upon Medicaid to meet their AIDS-related health care expenses. Id. at 70. In light of the fact that in 1989 the Medicaid program covered less than one-tenth of the nation's total population that private insurance did,[2] it is clear that the demand on Medicaid to finance this care has been disproportionately large. More disturbingly, AIDS-related health care financing is in the midst of a transformation known as "Medicaidization". "The National Center for Health Statistics reports that the share of inpatient care for AIDS that is financed by public sources (primarily Medicaid) rose from 25% in the 1984-85 period to 41% in the 1986-87 period, while the private insurance

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[2]In 1989, Medicaid provided coverage for 7.4% of the nation, while private insurance reached 77.0%. Health Insurance Association of America, Source Book of Health Insurance Data 25, 25-6 (1991) [hereinafter 1991 HIAA Source Book].

share declined from 49% to 43%." Green & Arno, supra, at 1261.

In addition, AIDS experts have calculated that Medicaid funds the nation's AIDS-related care at a rate two and one-half times greater than it does so for the nation's health care needs overall.[3] Given that reality, the latest estimates suggest that Medicaid contributed $1.100 billion in 1991 toward addressing the costs of treating AIDS.[4] Furthermore, according to total AIDS care cost projections for 1992-94, the burden

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[3]"Medicaid pays for 11% of total health care costs in the United States. By contrast, the Health Care Financing Administration estimates that Medicaid funds 25% of AIDS care." Green and Arno, supra, at 1261. Since Medicaid reimbursements are not on-par with private insurance reimbursements, it is not surprising that while Medicaid covers 40% of the AIDS population, its share of AIDS care funding drops to 25%.

[4]The Division of Cost and Financing of the Department of Health and Human Services' Agency for Health Care Policy and Research estimates that nationally $4.398 billion was expended in 1991 toward the costs of treating people with AIDS. Hellinger 1991-1994 Forecasts, supra, at 223.

on Medicaid is expected to rise to $1.361 billion in 1992, $1,643 billion in 1993, and $1.965 billion in 1994.[5] The basic message emanating from these figures is that the federal government's Medicaid program can anticipate a significant increase, both in dollar value and percentage share terms, in the resources it must devote towards AIDS-related health care payments.

However, in these days of governmental red ink, the climate is ripe for retraction of the Medicaid budget. Medicaid benefit payments have mushroomed from $48.7 billion in 1988 to $54.5 billion in 1989 and $64.9 billion in 1990. 1991 HIAA Source Book, supra, at 43. This represents a growth in payments of 12.6% and 19.0%, respectively. One prominent

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[5]The corresponding projected total costs for AIDS treatment are $5.444 billion in 1992, $6.572 billion in 1993, and $7.859 billion in 1994. Id. at 223.

example of the clamor for fiscal belt-tightening in federal health expenditures lies in President Bush's recent proposal regarding the nation's health care crisis. The President's idea of utilizing tax credits and tax deductions to make health insurance accessible to the poor will have to be offset by some other component of the federal government's budget for health-related issues.

With administration cost estimates for the plan ranging from $55 to $100 billion over five years, "Members of Congress who have been briefed on the plan by Administration officials estimate that . . . 60 percent [of the money would come from] Medicaid." Robert Pear, Bush Health Plan would be Financed by Medicare Curb, N.Y. Times, Feb. 3, 1992, at A9, col. 4. In other words, the Medicaid budget must eliminate an average of $6.6 billion to

$12 billion per year in payments to fund the Bush plan. Irrespective of whether national health care reform actually occurs, the ability of Medicaid to satisfy the projected demand for AIDS-related disbursements will be subject to serious budgetary challenge. Thus, the additional demand on the Medicaid system that will be induced by discriminatory practices similar to those of H & H Music Company will further strain a public insurance system that can ill afford it.

Budgetary pressures notwithstanding, the Medicaid program is under court order to pay for a drug, zidovudine (also known as AZT or by the brand name Retrovir).[6] AZT is an antiretorvirus used by persons

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[6] "[Zidovudine] has been shown to be of clinical value and remains the foundation of all expected strategies for the treatment of HIV infection (emphasis added)." Paul A. Volberding, Recent Advances in the Medical Management of Early HIV Disease, 6 J. Gen. Internal Med. S7, S9 (Jan./Feb. 1991 Supp.).

with HIV to delay the onset of opportunistic diseases which occur if the HIV virus depletes the body's CD4 cells. In Weaver v. Reagen, 886 F.2d 194 (8th Cir. 1989), the Eighth Circuit upheld the lower court's decision in a class-action suit that mandated that the Missouri Medicaid program is "enjoined from denying coverage of Retrovir to persons eligible for Medicaid and infected with the AIDS virus." Weaver v. Reagen, 701 F.Supp. 717, 726 (W.D. Mo. 1988). In acknowledging the medical necessity for this type of treatment, the 8th Circuit invalidated Missouri's decision to restrict Medicaid reimbursements for Retrovir treatment to only those persons who met certain medical conditions.[7] In

[7]Weaver, 886 F.2d at 200. The Missouri Medicaid program's clinical prerequisites were that a person have either a history of cytologically confirmed Pneumocystis carinii pneumonia (PCP) or an absolute CD4 (T4

doing so, the Eighth Circuit effectively expanded the group of people that would be legally entitled to Medicaid payments for this type of AIDS-related treatment. A district court in Kansas reached a similar outcome two years earlier. See Mair v. Barton, 705 F.Supp. 520 (D.Kan. 1987).

Virtually all states have opted to fund AZT treatments for Medicaid recipients. National Gay Rights Advocates, Access to AIDS-Related Drugs Under Medicaid: A Fifty State Analysis, reprinted in AIDS Reference Guide: A Sourcebook for Planners and Decision Makers (Atlantic Info. Services) ¶ 326, at 3 (Aug. 1989). In view of this present voluntary commitment by the vast majority of state Medicaid agencies to prophylatic treatments, a sudden and significant increase in the number of AIDS-related

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helper/inducer) lymphocyte count of less than two hundred per cubic millimeter). Id. at 196.

Medicaid recipients clearly threatens the viability of these programs. Medicaid programs across the nation would face the unenviable choice of either restricting reimbursements for prophylatic treatments or incurring greater budget deficits to accomodate the needs of an expanded Medicaid-dependent population. By indirectly enlarging that population, the Fifth Circuit's decision will force Medicaid into this dilemma.

The undesired shift in health care financing portended by the Fifth Circuit's ruling also endangers the other component of the nation's health care "safety net": hospitals which provide uncompensated care. Two primary factors generate the need for uncompensated care, and the lower courts' decisions exacerbate both of them. The first consideration is the number of uninsured. Obviously, the greater the

population of patients whose care will not be reimbursed in full by private insurance, the greater the burden on hospitals to provide medical care free of charge. An unfortunate reality of the HIV/AIDS crisis is that a disproportionate number of persons with AIDS are uninsured. In 1989, 12.9% of the nation's population was not covered by either private or public health insurance. 1991 HIAA Source Book, supra, at 25. In marked contrast, 29% of the AIDS population is without insurance. National AIDS Commission Report, supra, at 70. Thus, the AIDS epidemic already requires an above-average amount of uncompensated care.

The other factor relates to Medicaid. Given Medicaid's policy of low reimbursement rates and the nation's imbalanced dependence on Medicaid for AIDS-related health care expenses,

hospitals serving AIDS patients who are Medicaid recipients will, in general, find themselves having to assume a significant amount of unpaid costs. As noted by a major hospital organization, "Without adequate public coverage, AIDS care will be 'paid' for in the form of uncompensated care for uninsured AIDS patients . . . ." AHA Report, supra, at 46. In this respect, the fate of uncompensated care is intertwined with the fate of Medicaid.

Since these two factors have figured so prominently in the HIV/AIDS crisis, it is not surprising that AIDS-related uncompensated care is sizable. Nevertheless, its extent is shocking, especially in relation to other uncompensated care. Comprehensive national survey data reveals that hospitals incurred a daily average of $136 in losses per AIDS patient. Dennis P.

Andrulis, Virginia Beers Weslowski & Larry S. Gage, The 1987 US Hospital AIDS Survey, 262 JAMA 784, 788 (1989) [hereinafter Hospital AIDS Survey]. By comparison, hospitals lost only $26 per non-AIDS medical/surgical patient, or less than 1/5 the loss stemming from the AIDS patient. To say that AIDS-related uncompensated care severely tests the financial well-being of the nation's hospital system is an obvious understatement. By allowing employers to engage in discriminatory practices with regard to health benefits, the Fifth Circuit's decision demands even greater levels of uncompensated care from an already heavily burdened hospital system.

The uncompensated care issue has an interesting twist to it. Apparently, a dichotomy exists in the sharing of this burden, and it occurs along the lines of

the public-private distinction. While both public and private hospitals do sustain losses on AIDS patients, the public hospital's unpaid bill is more than twice that of the private hospital.[8] The underlying description of this phenomenon suggest a troubling dimension to AIDS-related uncompensated care:

> Public hospitals admitted a significantly higher percentage of PWAs [persons with AIDS] whose payer source was Medicaid (52% of admissions to private institutions) and a higher proportion of self-pay/other [generally the uninsured or the indigent] (31% vs 13% for private hospitals). Private hospitals admitted a larger proportion of patients who were privately insured (48% vs 13% for public hospitals.

Id. at 789.

In general, public hospitals shoulder more of the burden of caring for those

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[8]The private hospital's loss per patient per day stands at $92, in contrast to the public hospital's figure of $218. Hospital AIDS Survey, supra, at 788. This disparity is not reserved for AIDS-related care: private hospitals, on average, gain $12 per day per non-AIDS patient while public hospitals face a loss of $131. Id.

persons with AIDS who are least able to pay for their care. Yet, "public hospitals treated, on average, more than twice as many AIDS patients as private hospitals in 1987." Id. at 786. Accordingly, "public hospitals have been experiencing significant economic losses when they provide care to AIDS patients." National AIDS Commission Report, supra, at 75. Thus, the more public hospitals undertake to provide care to those deprived of private insurance, the more they place themselves in a position of being financially unable to respond to this need for uncompensated care. As this need for uncompensated care increases in response to the kind of employer behavior sanctioned by the Fifth Circuit, the financial health of those very hospitals which are disproportionately providing care to persons with AIDS in

dire need of free or near-free care will be adversely impacted even more.

The potential size of the damage is staggering. If presently commercially insured employers do convert to self-insurance to take advantage of penalty-free alteration of employee health benefits, Medicaid and uncompensated care will face an onslaught of AIDS-related health care costs. In 1989 alone, AIDS-related employee health care claims paid by the insurance industry amounted to $455 million. Christine Woolsey, AIDS Claims Hit $1 Billion, Bus. Ins., Oct. 29, 1990, at 1. This represents "an alarming 83% increase" from such payments in 1988. Id. Moreover, insurance industry observers acknowledge that these figures probably understate the actual amount of payments made by insurance companies on employee

AIDS-related health insurance claims. Id. at 38.

These developments clearly threaten the integrity of the health care "safety net". The strain on public hospitals "erodes their ability to provide specialized services and threatens their traditional mission as the provider of last resort of the indigent." AIDS Update: An Executive Report--Public Hospitals Bear Brunt of AIDS Treatment Load, Hospitals, May 5, 1990, at 26. Both public and private hospitals have financed the burden of uncompensated care in the form of higher health care costs to the public as a whole. However, "as competition decreases the ability of hospitals to shift these costs, hospitals may find themselves struggling to meet the needs of AIDS patients." AHA Report, supra, at 46. In essence, this struggle

depicts the overall problem: as the responsbility of caring for HIV-infected persons becomes increasingly a matter that Medicaid and uncompensated care address by default, the ability of the entire "safety net" to respond to other similar public health crises is seriously compromised.[9]

C. The use of McGann-like health benefit caps unconscionably denies many HIV-infected individuals access to the most effective life-prolonging and medically necessary treatments available.

The health benefit caps condoned by the Fifth Circuit have a direct bearing on the quality of health care that formerly-insured employees must receive if they become or are infected with HIV. Sadly, Medicaid's established reputation as a

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[9]"If financial responsibility [is] shifted to the public sector, limited resources would be diverted to individuals who would otherwise be able to finance their own care. These resources then would not be available for those with significant need or for other vital programs." AHA Report, supra, at 39.

below-market-price reimburser limits a Medicaid recipient's accessiblity to the medically necessary level of care.

> [P]hysicians have financial disincentives to provide care to individuals on Medicaid. Physician reimbursement rates under Medicaid are much lower than those from other third-party payers . . . . In this climate, not only may patients be forced to wait for care until serious symptoms develop, but they then are likely to be driven for lack of alternatives to seek care in the more expensive hospital emergency room or inpatient setting.

National AIDS Commission Report, supra, at 75.

Moreover, though it is heartening that hospitals extend uncompensated care to the uninsured, that care is generally inferior. In several key categories measuring patient well-being, privately insured hospital patients fare better than their uninsured counterparts. For instance, where a high-cost/high-discretion hospital procedure is involved, "the uninsured's length of stay is

significantly shorter than the length of stay for the privately insured . . . ." Jack Hadley, Earl P. Steinberg & Judith Feder, Comparison of Uninsured and Privately Insured Hospital Patients, 265 JAMA 374, 377 (1991). Related to this is the fact that there are "highly significant and quantitatively large differences between uninsured and privately insured patients in the probability of undergoing these procedures." Id. The final and perhaps most sobering observation is that "the uninsured have a higher relative risk of in-hospital death than the privately insured." Id. at 379.

One of the most hopeful discoveries in the battle against AIDS and HIV-infection is the use of AZT. As mentioned earlier, these types of drugs delay the onset of crippling opportunistic diseases

like PCP. Since the AIDS virus devastates the body's immune system, opportunistic diseases normally kept at bay are free to wreak havoc within that body. In essence, the fatality of AIDS stems from these diseases. Yet, although the drug AZT was originally targetted for HIV-infected persons who had developed PCP, subsequent medical studies have established that AZT is equally efficacious when administered in a prophylatic mode. Consequently, "[the Centers for Disease Control] estimates that approximately 60 percent of HIV-infected individuals would benefit from immediate treatment with [AZT]." National AIDS Commission Report, supra, at 75.

One setback with both the prophylatic and the intial use of AZT has been the toxicity associated with originally prescribed dosage levels. Volberding,

supra, at S7, S9. Definitive clinical studies now recommend that lower dosages can be applied without fear of reducing the effectiveness of AZT at any stage of HIV infection: asymptomatic, early, or advanced HIV disease. Id. at S9-S11. While AZT--as well as other drugs under investigation--is not a "miracle drug", its value to anti-HIV-disease treatment is substantial. Thus, ready access to AZT is an urgent priority for improving the lives and extending the life spans of HIV-infected persons.

AIDS-specific employee health benefit caps represent a direct threat to this critical access. Caps also severely harm an employee who suffers from an opportunistic disease. Amici do not attack the concept of cost-containment in general. However, cost containment cannot be disciminatory under ERISA. Therefore,

amici urge the Cour to recognize this "cost-cutting" tactic undertaken by H & H Music Company and supported by the Fifth Circuit for what it really is--an illegal death-promoting denial of promised employee health benefits.

CONCLUSION

For the foregoing reasons, the judgment below should be reversed.

Respectfully submitted,

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